

The Commonwealth of Massachusetts
Division of Professional Licensure
239 Causeway Street, 5th Floor
Boston, MA 02114

Board of Registration of Allied Mental Health
and Human Services Professions
(617)727-3080

APPLICATION INFORMATION FOR LICENSURE AS A REHABILITATION COUNSELOR

Please Read the Following Information Prior to Completing the Application.

Prior to completing the application, obtain a copy of 262 CMR from the State Bookstore, Room 116, State House, Boston, MA 02133, (617) 727-2834, or online <http://www.state.ma.us/reg/boards/mh>

EXAMINATION INFORMATION


All applicants must pass the Certified Rehabilitation Counselor Examination in order to be approved for licensure. You may take the examination without applying for CRC designation. If you have not yet taken the examination, please see #9 of the application for registration deadlines. If you have already passed the examination, please submit an official score report with your application.

IMPORTANT POINTS

1. Carefully review both the regulations and the application before filling out the application.
2. Please fill out the requested information in clear, legible printing or typing.
3. Applicants are urged to make a copy of their application for their personal records.
4. Submit the completed application, supporting documentation, and required application fee of 102.00 to the Board at the address listed above. The Board will not advise individuals as to their eligibility for licensure until a complete application with supporting documentation has been reviewed. Licensure eligibility can

only be determined through the application process. Individual Board members cannot make decisions on the eligibility of an applicant, the acceptability of the courses taken, or the setting of clinical/work experience.

5. Once your application is approved, a \$135.00 initial license fee is due.



BOARD USE ONLY Board: _____ License#: _____ Type: _____ Cash#: _____ Cash Date: _____

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Please attach recent passport type

2" X 2"

head and shoulder photograph

**REHABILITATION COUNSELOR
LICENSURE APPLICATION
NON-REFUNDABLE FEE: 102.00**

1. Name: _____
Last First Middle Maiden

2. Mailing Address: _____
 No. Street Apt. No.

 City/Town State Zip Code

3. Date of Birth: _____ Place of Birth: _____

4. Tel. No. Day: _____ Evening: _____

5. USA SOCIAL SECURITY NUMBER (MANDATORY) _____ - _____ - _____

Pursuant to G.L. c. 62C, s. 47A, the Division of Registration is required to obtain your social security number and forward it to the Department of Revenue. The Department of Revenue will use your social security number to ascertain whether you are in compliance with the tax laws of the Commonwealth.

6. Graduate School Attended: _____ Degree: _____ Credits: _____

Major: _____ Date Conferred: _____

NOTE: Official graduate level transcripts must be included with application, with a minimum of 48 graduate credits in rehabilitation counseling.

7. **DISCIPLINARY HISTORY**

If you answer "YES" to any of the following questions (A - F), please attach a complete explanation.

A. Has any disciplinary action been taken against you by a licensing/certification board located in the United States or any country or foreign jurisdiction? YES
____ NO ____

B. Are you the subject of pending disciplinary action by a licensing/certification board located in the United States or any country or foreign jurisdiction? YES
____ NO ____

C. Have you ever voluntarily surrendered or resigned a professional license to a licensing /certification board in the United States or any country or foreign jurisdiction? YES ____ NO ____

D. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction? YES ____ NO ____

E. Have you ever been convicted of a felony or misdemeanor in the United States or any foreign jurisdiction, other than a traffic violation for which a fine of less than \$100.00 was assessed?

YES ____ NO ____

8. PROFESSIONAL LICENSES/REGISTRATIONS

List any professional licenses/registration you hold or held in the United States or any country or foreign jurisdiction and the state/jurisdiction from which the license/registration was issued along with the license number. _____

9. CERTIFICATION STATUS

a. Do you have a current certification/membership as a Certified Rehabilitation Counselor by the Commission on Rehabilitation Counselor Certification?

____ Yes ____ No If yes, please attach a copy of your certification.

b. Do you plan to take the CRC examination? ____ Yes ____ No

If applicable, please check the date you will be taking the examination. Applications received after the deadline will register you for the next available exam.

<input checked="" type="checkbox"/>	<u>Filing Deadline</u>	<u>Examination Date</u>
<input type="checkbox"/>	November 10, 2003	April 26, 2004
<input type="checkbox"/>	June 10, 2004	October 26, 2004

10. PRE-MASTER'S DEGREE SUPERVISED CLINICAL EXPERIENCE

Provide copies of Form 16 - Statement of Supervised Clinical Experience to your approved supervisor(s) to document hours of experience and return with this application. Attach additional information as necessary.

Student Practicum

Name and address of Facility: _____

Nature of Practicum: _____

Dates of Practicum: From _____ To _____

Month/Day/Year

Month/Day/Year

Your Title _____

Name of Supervisor and Title _____

Student Internship

Name and address of Facility: _____

Nature of Internship: _____

Dates of Internship: From _____ To _____
Month/Day/Year Month/Day/Year

Your Title _____

Name of Supervisor and Title _____

11. POST-MASTER'S WORK EXPERIENCE

Please complete Form 15A and 15B describing relevant post-master's degree work experience. Provide copies of Form 16 - Statement of Supervised Clinical Experience to your approved supervisor(s) to document required hours of supervised clinical experience.

Return completed form(s) with this application. Attach additional information in this format as necessary to document required hours.

12. Pursuant to M.G.L., Chapter 62C, S. 49A, I have filed all state tax returns and paid all state taxes required under law. ____Yes ____No. If No, please explain. _____

13. Pursuant M.G.L., Chapter 119, S. 51A and M.G.L., Chapter 112, S. 1A, my signature to this application is my certification I understand my obligation to report the abuse or neglect of children.

14. AFFIDAVIT

I certify, that I agree to abide by the M.G.L., Chapter 112 and the Rules and Regulations for the licensing of Rehabilitation Counselor as contained in 262 CMR and attest that all statements made herein are truthful and are made under the pains and penalties of perjury.

Sign in the presence of a Notary.

Applicant's Signature

Date

Notary Signature

My Commission Expires On

15B. WORK EXPERIENCE/REHABILITATION COUNSELING

Refer to 262 CMR for qualifying work experience requirements.

QUALIFYING WORK EXPERIENCE AREAS:

YES NO

(1) Job Placement/Development For A Special Population/Vocational Analysis/ _____

Transferable Skill Assessment

For example, did the rehabilitation counselor (RC) use counseling techniques to prepare clients for activities of job hunting? Did the RC instruct clients about ways to locate jobs? Did the RC role-play employment interview and review employer questions with clients? Did the RC visit employers to solicit job openings for particular clients? Did the RC set up job interview appointments for clients? Did the RC make on-site employer contacts to determine the tasks, physical and mental, which comprised the job? Did the RC evaluate job activity at the work site to determine if modification of the work activities were needed? Did the RC perform modification of the job tasks to accommodate client's disability? Did the RC determine appropriate job options?

(2) Vocational Assessment & Evaluation For A Special Population? _____

Did the RC use test results as diagnostic aides to understand the whole client? Did the RC interpret testing results to the client? Did the RC incorporate testing results in the formulation of vocational rehabilitation goals? Did the RC discuss specific vocational alternatives which were compatible with client training, experience and disability limitations?

(3) Medical Aspects of Disability _____

For example, did the RC appraise client's psychological readiness for rehabilitation services? Did the RC decide if medical and/or psychological examinations were required of clients?

(4) Vocational and Effective Counseling For A Special Population _____

For example, did the RC assist in reducing client's anxiety by helping them face and realistically assess problems that seemed insurmountable? Did the RC aid the client to better understand and when necessary, change their feeling about themselves and others? Did the RC interpret the motivations underlying client's behavior and assist client's to identify relevant issues which required modifying behaviors and/or attitudes? Did the RC assess the vocational significance of client's disabilities?

(5) Rehabilitation Plan Development _____

For example, did the RC review client's progress in the vocational rehabilitation program? Did the RC brief cooperating agencies when referring clients? Did the RC refer clients to other agencies for needed services? Did the RC develop and prepare written rehabilitation plans with the client? Did the RC conduct and take interviews to determine how the RC and the agency could help clients? Did the RC integrate vocational, medical, and psychological diagnostic information to formulate rehabilitation goals?

Name: _____

15A. WORK EXPERIENCE/ REHABILITATION COUNSELING - Post-Master's Degree Only

List all relevant work experience with a special population including private practice, in chronological order (most relevant experience first).

Special Population includes persons who have one or more physical or mental disabilities resulting from amputation, blindness, cancer, cerebral palsy, cystic fibrosis, deafness, heart disease, hemiplegia, hemophilia, respiratory or pulmonary disease, multiple sclerosis, muscular dystrophy, musculoskeletal disease or disorder, quadriplegia and/or spinal cord conditions, sickle cell anemia, substance abuse, end stage renal disease, neurosis and/or psychosis or another disability or combination of disabilities causing functional limitations.

1. Name/ Address of Facility	Dates	Hours of Experience	Hours of Supervision
2. Name of Supervisor			

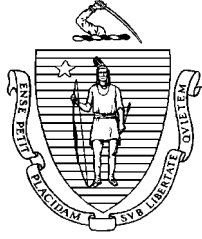
A) 1. 2.	From: _____ To: _____	a) Hours per Week _____ b) # of Weeks _____ (a x b) _____	a) Hours per Week _____ b) # of Weeks _____ (a x b) _____
B) 1. 2.	From: _____ To: _____	a) Hours per Week _____ b) # of Weeks _____ (a x b) _____	a) Hours per Week _____ b) # of Weeks _____ (a x b) _____

Minimum - Master's Degree

3,360

200

Please photocopy and complete additional pages in this format if necessary



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FORM 16 – STATEMENT OF SUPERVISED CLINICAL EXPERIENCE

Please duplicate this form as necessary to document total number of required supervised hours. See reverse side of this page for definitions of Approved Supervisor.

Name of Applicant: _____

Remainder of Form to be completed by Approved Supervisor

Name of Supervisor: _____

Address: _____

City: _____ State: _____ Zip: _____

Supervisor's Title: _____

Name/Address of Clinical Facility: _____

Nature of Facility: _____ Setting of Facility: _____

Dates of Supervision of the Applicant—From: _____ To: _____

Number of Supervision Hours—Individual: _____ Group: _____

Total Number of Supervised Hours During This Period: _____

Description of Applicant's Duties: _____

Please include an explanation if any disciplinary action has been taken against you within the last ten years by any of the following:

<u>Professional Association or Organization:</u>	Yes: _____	No: _____
<u>Governmental Authority (e.g. Professional Licensing Board):</u>	Yes: _____	No: _____
<u>Third Party Insurance Carrier:</u>	Yes: _____	No: _____
<u>Credentialing Board:</u>	Yes: _____	No: _____

I have read the definitions of Approved Supervisor listed in 262 CMR and/or on the reverse side of this page and believe that I qualify as an approved supervisor. The undersigned states that under the pains and penalties of perjury, that the above statements are true and correct.

Signature of Approved Supervisor

Date

DEFINITION OF APPROVED SUPERVISOR (262 CMR)

A supervisor must possess the qualifications of one of the categories below in order to be acceptable as an Approved Supervisor by the Board. See 262 CMR 4.02(2).

- a) A rehabilitation counselor currently certified as a CRC by the CRCC;
- b) A currently licensed rehabilitation counselor, or an individual who meets the qualifications for licensure as a rehabilitation counselor by the Board; or
- c) A person who has a minimum of five years of clinical experience in rehabilitation counseling and either:
 - 1. A master's degree in rehabilitation counseling or related field;
 - 2. A doctorate in psychology; or
 - 3. A medical degree with a subspecialization in psychiatry.